HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 3 November 1999
(*Morning*)

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HEALTH AND COMMUNITY CARE COMMITTEE
11th Meeting

CONVENER:

*Mrs Margaret Smith (Edinburgh West) (LD)

COMMITTEE MEMBERS:

*Malcolm Chisholm (Edinburgh North and Leith) (Lab)
*Dorothy-Grace Elder (Glasgow) (SNP)
*Mr Duncan Hamilton (Highlands and Islands) (SNP)
*Hugh Henry (Paisley South) (Lab)
*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)
Ms Irene Oldfather (Cunninghame South) (Lab)
*Mary Scanlon (Highlands and Islands) (Con)
*Dr Richard Simpson (Ochil) (Lab)
*Kay Ullrich (West of Scotland) (SNP)
*Ben Wallace (North-East Scotland) (Con)

*attended

THE FOLLOWING MEMBER ALSO ATTENDED:

Iain Gray (Deputy Minister for Community Care)

WITNESSES:

Dr John Garner (Chairman, British Medical Association Scottish Council)
Dr Kenneth Harden (Chairman, BMA Scottish General Practitioners Committee)
Mr Rab Hide (Deputy Chairman, BMA Scottish Council)

COMMITTEE CLERK:

Jennifer Smart

ASSISTANT CLERK:

Irene Fleming

COMMITTEE ADVISER:

Dr John Forbes

Scottish Parliament

Health and Community Care Committee

Wednesday 3 November 1999

(*Morning*)

[THE CONVENER *opened the meeting at 09:30*]

The Convener (Mrs Margaret Smith): Let us begin this meeting of the Health and Community Care Committee. The first thing that we must do is discuss our line of questioning for the witnesses from the British Medical Association. We shall discuss that formally in private without the presence of the official report or the broadcasters. Is the committee agreed?

Members *indicated agreement.*

09:31

Meeting continued in private.

09:38

On resuming in public—

Arbuthnott Report

The Convener: I welcome our visitors from the BMA. Good morning, gentlemen. Please introduce yourselves to the committee and, if you want to, give a short statement to precis some of the points in your written submission. We will then ask you questions about your submission and about the report in general.

Dr John Garner (Chairman, British Medical Association Scottish Council): Thank you. We are delighted to have this opportunity to give evidence to the committee and to answer members' questions. We are keen to contribute constructively to the debate on a range of issues about health and health care provision in Scotland. We are pleased that our invitation here today signals a much more open form of parliamentary democracy.

The British Medical Association in Scotland represents about 13,000 members from all branches of the profession—medical students, junior doctors, consultants and general practitioners. That representation is channelled through the democratically elected Scottish council, of which I am privileged to be chairman.

With me are Mr Rab Hide, a consultant neurosurgeon at the Southern general hospital in Glasgow and chairman of the consultants and specialist services committee of the BMA, and Dr Kenneth Harden, chairman of the Scottish general practitioners committee of the BMA and a GP in Glasgow. They will help to answer any questions.

I will start with a few general remarks about the report "Fair Shares For All". Last year, the BMA's policy was encapsulated in two short statements. We said that the Government should continue to confront the most potent cause of poor health, which is poverty, and that we recognised that health was determined not only by health services, but by political, social, environmental and personal factors. We also called for the development of and wider use of health impact assessments in all areas of national and local public policy.

We are very supportive of the aims of the Arbuthnott report to address health inequalities. We accept, however, that the Arbuthnott report covers only the division of the health service cake, which is only part of the answer in reducing health inequalities.

In the past century, the principal improvements in health have come not from people like us—nurses and doctors—but through better sanitation and water supplies. In the next century, we hope, much will be achieved through better education, diet, housing, transport and the reduction of poverty.

The BMA is concerned that Arbuthnott has not addressed the overall size of the cake. We would argue that a significant uplift in resourcing is needed to achieve the goal of health equality for all.

We broadly welcome the report and the principles that underlie it. We recognise that, for acute services, the report represents only a small shift from the Scottish health authorities revenue equalisation formula, but that such fine tuning is important. Based on the evidence available to it, we acknowledge that the Arbuthnott review has produced a very professional report. We particularly liked the recommendation that evaluation and refinement should continue. We also agree that some areas, which are listed in the report, require additional research.

We want the Health and Community Care Committee to consider the issue of unmet need, which is talked about a lot in the report, and how unmet needs vary across the country.

Met wants can also vary across the country and must be provided for. Met wants are the things that the health service and taxpayers pay for but that may not result in positive health outcomes. Met wants could include, therefore, explaining to a 63-year-old fit male who comes into a surgery that he does not require a flu jag as he is not at risk—that takes time and resources. They may also include dealing with a drug addict who comes in

for an increase in his drug prescription. That takes time, investment and resources, but it does not result in a positive health improvement. Met wants may also affect hospital accident and emergency departments. For example, a chap may return with a sore back because he wants an X-ray and a second opinion. Again, that is not improving health, but it is something that we on the front line, and especially in general practice, have to deliver. We want that area to be explored.

The proposal to bring about changes to hospital and community funding though differential growth is welcome. However, the suggested time scale of six years is dependent on the size of those general and specific uplifts. A tension exists between the need for change and the need for minimal disruption. A low uplift in a potentially losing board would make it difficult for that board to fund new, essential developments. If the committee wants, we can talk about those developments.

9.45

We are disappointed that the review did not propose that the additional resource provision should be targeted at the causes of health inequalities that have given rise to this redistribution exercise. We are keen that only effective treatments with positive and proven health outcomes should be used. Members may have seen *The Scotsman* on Friday, in which our colleague GPs in Easterhouse expressed their worries about the allocation of public moneys to baby massage, reflexology and acupuncture, which do not address the real problems of health inequalities in Easterhouse. Our members were concerned about that.

Finally—and I know that this is an area of particular interest for the committee—we have major concerns about the suggested indicative allocations for non-cash-limited general medical services. We believe that further work and discussion is needed in those areas before implementation.

We have three principal concerns. The first is the lack of a reality check, as we call it, on the proposed formula for the non-cash-limited GMS. The idea that there can be a reduction or a zero growth in GMS resource at a time when we are emphasising the shift of resources from secondary care to primary care is, in our view, untenable. Secondly, we have concerns about the way in which remoteness and rurality have been measured. Finally, we have concerns about the continuous morbidity recording in the report. Dr Kenneth Harden, who is the chairman of the Scottish general practitioners committee, is happy to give a short presentation on those three areas, if the committee wishes.

Overall, the BMA is saying that the report represents a good start, but that more work needs to be done. We welcome the opportunity to be part of that additional work. Thank you, convener, for allowing us time.

The Convener: We certainly intended to question you on two of those last three things that you mentioned, so it would be useful to hear from Dr Harden first.

Dr Kenneth Harden (Chairman, British Medical Association Scottish General Practitioners Committee): As John Garner was saying, Scottish GPs welcome the development for the first time of an equitable distribution model. However, it is essential to recognise the deficiencies of the model that has been proposed. Several loading factors are used for GP payments. One of the main ones is continuous morbidity recording. That system is based on a number of volunteer practices. Inevitably, a system that bases itself on volunteers is atypical. That is illustrated by the fact that, for example, the system involves only 6 per cent of the practices but covers about 11 per cent of the population of Scotland. The practices are substantially bigger than average. Only 3 per cent qualify for deprivation payments as opposed to 11 per cent of practices in the country as a whole. The only aspect of work load recorded in the system is the number of consultations, whereas, for a true record of work load in general practice, it is clearly important also to record the duration of the consultations and other aspects such as telephone consultations and nurse consultations.

We were concerned that the method of validating sparsity in general practice used the current payment structure, which seems to us to be a rather circular logic. Some methods of measuring actual additional costs seem to be much more appropriate than using the existing payments system. Some of the results produced are counter-intuitive—for example, the suggested major reduction in the funding of GMS in the Borders.

We note with regret that the Arbuthnott committee does not seem to have taken dispensing payments into account in its calculations. That has a significant effect on payments to GPs in rural areas who do dispensing as well as general medical services.

The report did not consider the problem of inducement practices. Where a practice is considered essential, the current arrangements ensure the payment of more than 80 per cent of average intended net remuneration to inducement GPs. It is unlikely to be possible to ensure the provision of adequate GMS in those areas without the inducement scheme or a comparable expenditure. There seems to be a case for top-

slicing the payment in terms of the irreducible minimum of such areas.

The move to a rational, equitable basis for allocation of GMS is welcomed, but much work is needed to establish a more robust system to measure both need and demand in primary care. Considerable thought and planning is required to establish an effective and safe method of implementing necessary change.

The Convener: Thank you for that full and useful statement.

Mary Scanlon (Highlands and Islands) (Con): I have quite a few questions. As a member for the Highlands and Islands, I was delighted by the report, because we seemed to be one of the winners. However, my delight was short lived because you say in your submission that the Highlands will lose 20 to 30 GPs. You also say that Orkney will lose 40 per cent of its GPs, that Shetland will lose 33 per cent of its GPs and that the Borders will lose half its GPs. We are looking towards primary care for health promotion, monitoring heart disease and meeting the Government's targets, but if the money is not going to primary care, where is it going?

The second point that you raised was the transfer of resources—that issue was also raised by Graham Watt. We have a concern about the volume of the transfer of resources from secondary to primary care.

How can we be sure that the resources will address poverty, inequality and deprivation? If the Highlands are going to benefit, how can we be sure that the crucial problems of poverty and deprivation will be met by those resources? It looks as though the money is going into a big pot—beyond that, it is neither monitored nor checked.

Dr Harden: Those are cogent points, which need to be addressed. We need a robust method of measuring the factors such as deprivation. The present system of measuring work load—through CMR—does not adequately do that because of the atypical nature of the practices. As you rightly point out, the redistribution of resources has major implications. In the Borders, for example, there is a suggested reduction of 27 per cent and, in Shetland, there will be 39 per cent less.

Mary Scanlon: If I might correct you, the figures for the Borders seem, in your submission, to suggest a reduction in the number of GPs from 77 to 38.5—a 50 per cent reduction.

Dr Harden: Let me explain that point. The reduction in resources is 27 per cent, but the implication of the reduction in resources is much greater in terms of the numbers of GPs. Under the current system, there are certain basic payments, such as capitation fees, which continue. If the only reduction that can be made is in the number of GPs, the reduction costs have got to be in basic practice allowances. That will have a much greater effect on the number of GPs than the simple reduction in resources would indicate. That is why there is that difference in the number of GPs.

Mary Scanlon: Are you saying that if the recommendations are implemented, inequality of access, poverty and deprivation might increase? We will not have the GPs to carry out the services. If what you say is correct, the Arbuthnott committee will do the opposite of what it set out to do.

Dr Harden: The proposed formula poses a real danger and we welcome the fact that the Arbuthnott committee has suggested that the GP formula is purely indicative and out for consultation. The committee recognises, following our discussions with it, that there are major disadvantages, or defects, in the proposed system, which must be considered. As you rightly point out, if the proposed changes were made—for example, in the Borders, in Shetland or in Orkney—they would have major detrimental effects on the provision of GP services in those areas.

Dr Richard Simpson (Ochil) (Lab): I have a supplementary question. Are you saying to us that the GMS should be excluded from this process, because the data are inadequate? One of the questions at the beginning of your submission is this:

"Why has GMS been included in this at this point in time?"

However, this morning you are saying that, although you welcome the fact that someone is attempting to do something about the situation, the changes in GMS are so significant in Grampian, Borders, Lothian, Orkney and Shetland—as shown in table 14.5 in "Fair Shares For All"—that they would have a totally destabilising effect. Am I correct in thinking that?

Dr Harden: You are absolutely right, Dr Simpson. If this formula were applied now, it would have a major destabilising effect on services in those areas.

Mary Scanlon: That is worrying. I would like to continue the line of questioning that I started last week. Your submission states:

"We have a general concern that implementation of the report's recommendations will lead to a lowering of standards in those areas which are 'closing'."

I refer again to Lothian and the Highlands. Many specialist services are offered in Lothian, and the health board said that it would have to address that. The Highlands stand to lose not only GPs,

but some of the specialist services that cannot be offered in remote rural areas. Do you share that serious concern?

Mr Rab Hide (Deputy Chairman, BMA Scottish Council): Perhaps I can answer that. I understand what you say about the specific problems in rural areas. The possible knock-on effect in specialist services may affect all patients. Many of the services in question are tertiary or major secondary services.

There are two problems, which are perhaps not detailed in the Arbuthnott report, but which certainly impinge on that report's conclusions. In this country, we seem to have had difficulty in producing true costs—the true costs of procedures, of acute sector care and of general practice. We have tried, but seem to have failed, to develop a robust system of coping with what we call cross-boundary flow—of ensuring that money follows patients. Many words have been spoken and many theories put in place, but at the grass roots—at the coal face, rather—it sometimes seems that that is not happening. That was a distorting factor in the care formula.

Mary Scanlon: It is all very well for us to be critical. However, can the BMA provide a workable definition of equity of access to GPs, irrespective of the density or profile of the population?

Mr Hide: I will turn my microphone off to answer that question if I may, convener.

The Convener: No. We get into trouble if we do that kind of thing.

Mr Hide: That is a matter that concerns the English language as much as the Arbuthnott report, but I would be delighted to hear my colleagues' responses. I have my own thoughts about equity and equality of access.

Kay Ullrich (West of Scotland) (SNP): We are talking about the implementation of a new system of distribution. Looking back to the implementation of the SHARE formula, can you provide any evidence that that formula had any effect on the quality of care in different health board areas?

Mr Hide: One of the difficulties that I have perceived in the reports and some of the transcripts is the interpretation of the data that are available. I have been a consultant in the Scottish health service for 30 years and I have little doubt that, following the SHARE report, there has been a considerable improvement in basic medical care facilities in many health boards that were relatively deprived before. Argyll and Clyde Health Board and Ayrshire Health Board, for instance, were able to develop core specialist services. The difficulty was that the report affected some of the major centres that supply services beyond the core ones, as we have heard from Lothian Health and Greater Glasgow Health Board.

10:00

Malcolm Chisholm (Edinburgh North and Leith) (Lab): I would like to consider further the numbers of GPs, as that was the headline story on the radio this morning and I suspect that it will be in the headlines after today's committee. Your submission contains other important points, but we need to clarify what we are talking about.

I understand that the cash-limited GMS will kick in more slowly than the main parts of the Arbuthnott recommendations; as the GMS that is not cash limited is just indicative, it could be argued that it will not kick in at all. Perhaps it is misleading to cite those GP figures, because to do so implies that the changes will be made immediately.

The general model for Arbuthnott is that changes will kick in according to the growth rates in the health budgets—I agree with Dr Garner that that is right. If that is true for the GMS figures as well, what is being suggested is a levelling up and there should be no cuts in the GMS budgets. If that is what Arbuthnott intended, would you be happy with that?

The professor of general practice at Glasgow—although Glasgow gains from the change in formula—suggested to us that not enough account has been taken of factors such as deprivation and inequality. Do you accept that adjustments will have to be made to GMS? If the adjustments involved a levelling up, would you be happy to accept them?

Dr Garner: I accept what you say: the figures are indicative. We are questioning whether they are correct. We want to know whether there has been a sufficiently full analysis of GP work load in tackling health problems. We are not convinced that the figures provide the right baseline.

Malcolm Chisholm: I accept what you are saying. I am aware that there are differences of opinion on this matter, but the professor of general practice at Glasgow said that if length of consultation and co-morbidity were taken into account, the adjustment might be large rather than small. That is open to question, obviously, and your point is that you want more work to be done on the figures.

Dr Garner: Absolutely.

Dr Harden: That is an important issue. We are suggesting not that there is no need for a formula, but that the formula is not based on evidence. It is based on an inappropriate sample, using inappropriate techniques.

You said that we should not worry too much

about the figures, as they are only indicative. However, many of us have seen indicative models rapidly become real models. If we do not register our objections to the basic principle and start to gather robust data, there is a major danger that inappropriate models will be imposed.

Malcolm Chisholm: Clearly, the Scottish Medical Practice Committee is important in relation to the GMS that is not cash limited. To what extent are factors such as deprivation and inequality taken account of in the allocation of money?

Dr Harden: As a member of the committee you mention, I am well placed to answer that question. At present, sparsity and rurality are taken account of by a formula that allows notional patients. Those formulae have not been used in the Arbuthnott report.

The other aspect is that the Scottish Medical Practice Committee has limited powers to influence distribution. It ensures that areas are not over-doctored, but it has little power to deal with the more important issue of areas that are under-doctored.

Dr Simpson: Does the SMPC take inequalities into account?

Dr Harden: It takes deprivation into account. It uses the existing deprivation payments to recognise deprivation and it uses the rural practice payments to recognise sparsity.

Dr Simpson: I am aware that you have already told us what changes you think would be brought about, but do you intend to conduct a study of the formulae and apply them to a set of assumptions so that they can be modelled?

Are the concerns that you expressed about the shifts related to the way development costs are considered, in terms of health costs and health inflation?

Dr Harden: We have addressed the problems that your first point referred to with the Arbuthnott committee. It is considering the weaknesses in the current information. There is a need for some forum that can do more work in the area. I do not know whether that should be the Arbuthnott committee or its successor or whether the responsibility lies with the Scottish Executive.

Your question on development costs is important. The suggestion that you and Mr Chisholm made is that changes can be absorbed simply by standing still. That is a fallacy because applications for increases do not keep up with health inflation, although they might keep up with general inflation. If an area is not receiving significant additional resources, particularly for general medical services, it will have to cut down on other areas. We need development costs in primary care to extend the range of services to provide an extended range of intermediate services. There is no reference in the report to the development of intermediate care to provide services in a site that is more convenient to the patient and at a level that is more cost-effective.

Dr Garner: Dr Simpson made a point about the size of the development money. If a board has only a health-based rate of inflation, it will have no ability to resource essential new developments that come automatically. An example of that would be the introduction of the statins. They will be available throughout Scotland and will cause a significant increase in the health budget.

The losing boards need an ability to stand still as well as some money for essential new developments.

Kay Ullrich: In terms of CMR, you said that volunteer practices were atypical, Dr Harden. How were those volunteer practices identified? Were they identified through the British Medical Association?

Dr Harden: Not at all. They were written to and asked whether they were willing to take part in a voluntary project of data collection. A small payment was made for staff, but no payment was made for the GP.

The result was that in areas where practices were extremely hard pressed—such as very deprived areas—there was a great unwillingness to participate. The danger was that spending more time on data collection would be to the detriment of patient care. At that time, the purpose of the exercise was not made clear; at no point was it made clear that its aim was a logical redistribution of resources. If that had happened, I suspect that many practices would have been more willing to participate and would have done so more reliably.

Kay Ullrich: However, the request did go out to all GP practices?

Dr Harden: Only to those with particular computer systems.

Kay Ullrich: I see.

Dr Simpson: That is the majority.

Hugh Henry (Paisley South) (Lab): Something you said puzzled me. You started off by saying that certain things were recognised with payments, but that because no payments were made to GPs some were reluctant to participate. Is that correct?

Dr Harden: Yes.

Hugh Henry: You went on to say that one of the reasons that many doctors, particularly in hard-pressed practices, did not participate, was overstretching—people felt that it would be detrimental to patient care. I cannot understand

your argument that, if GPs had been paid, they would have participated and patient care would not have been prejudiced, but that patient care would have been prejudiced if they had participated without being paid. Am I missing something here?

Dr Harden: This is a resource issue. It is not about the GP wanting more money for himself, but about a greater input of general medical services being required. Let us take the example of a GP who has assumed the role of chairman of one of the local health care co-operatives. It is not expected that he will be able to do that job in addition to providing existing general medical services. Quite rightly, it has been recognised that he will need locum payments to cover his absence when he is away on local health care co-operative business. Similarly, if any sort of additional work load is created, there is the option of buying in extra locum help.

Hugh Henry: So any additional payments would have been used to purchase additional services, not to compensate GPs personally, and their reluctance to participate was the result of their inability to purchase extra services?

Dr Harden: That is correct. If I were a doctor in Easterhouse who was stressed because of the drugs problems there, and someone asked me to collect some data—without saying what those data were for—I would be inclined to give my attention to the drug addicts and the problems of the area, rather than to data capture.

Dorothy-Grace Elder (Glasgow) (SNP): One of the most frustrating things about this report is that a vast amount of work has been done on shifting money around—I call it spreading the margarine more fairly—but no extra money has been provided. I would like to refer you to a few points in your report.

First, you say:

"the Review Committee obviously takes a different view of the reliability of hospital data to doctors, who generally have little confidence in such data."

Could you expand a little on that?

Secondly, do you consider that this formula gives local boards and local doctors any protection against private finance initiative developers influencing the number of staff employed in hospitals, as has already happened?

My third point relates to the era of more expensive drugs that we may be entering. Multiple sclerosis patients have asked me about beta interferon prescribing in particular. Do you have any feedback on that?

The Convener: Dorothy, you are straying.

Dorothy-Grace Elder: It is what the public wants to know, Margaret.

The Convener: I gave you a certain amount of leeway when you pinched Margaret Jamieson's question, but you are now going into all sorts of other areas.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): If she had been here on time—

The Convener: Dorothy's key question was about the quality and availability of the data. In their oral and written submissions, several people have told us that they do not have a problem with the theory of this report, but with the fact that, if that theory is based on inadequate data or data that are rooted more in the acute services than in the primary and community services, it is very difficult to get a picture of future need, rather than a snapshot of the situation in the past. Could you comment on the reliability of the data, identifying any key gaps? We have already picked up on some of those.

Dorothy-Grace Elder: Excuse me, convener, are you cutting me out on the PFI question, or are you saying that that matter has already been covered? I did not hear it being covered.

The Convener: I do not think that that is the point of this morning's questioning, which is about the Arbuthnott report and the quality of the data that were available to the committee.

Dorothy-Grace Elder: That is all very well, but PFI will affect hospitals in a major way. With respect, I would like to hear the BMA's view on that and on what protection the formula may offer.

The Convener: Dorothy, you might like to hear the BMA's view on many things—I am interested to hear what the association has to say on any number of issues. No doubt, at some point in the future you will hear the BMA's view on PFI. Unfortunately, you will not hear it right now. What we are going to hear now is its view on the quality of the data that were available to Sir John and his team when they put together their report.

10:15

Dorothy-Grace Elder: We are definitely in the new democracy, then. Thank you.

Hugh Henry: That is just offensive. After coming to the meeting late, Dorothy is attempting to take it in a totally different direction.

Dorothy-Grace Elder: It is a direction that the public would like us to take.

Margaret Jamieson: Has Dorothy seen the front page of today's *Daily Record*?

Dorothy-Grace Elder: I have not read the *Daily Record* yet.

The Convener: Colleagues, I think that I have made my position on Dorothy's question clear. Is my decision backed by the majority of members of this committee? Is everyone happy that the questioning is going in the right direction?

Members: Yes.

The Convener: Thank you, you may continue, gentlemen.

Dr Garner: I will ask Mr Hide to respond to the first part of the question, about data verification and the quality of the data.

Mr Hide: If anybody around this table is not completely aware of the BMA's position—[*Laughter.*]

One of the difficulties with data is that when they support people's own point of view, they think that they are great, and that when the data do not they think that they are flawed. That is always a problem. Data in the acute sector fall into three main areas: activity data, which are generated largely by trusts; work load data, which are collected by a combination of professionals and managers; and clinical data.

Clinical data are flawed, in the sense that the coding exercise that takes place for individual patients is very often erroneous. However, the robustness of those data is acceptable overall, in a comparative sense. Those are the data that are produced by the information and statistics division. Because the data are wrong in detail, it would be difficult to use them to fine-tune things—to get accuracy, one would have to go back to the hospital in question and work through the basic records.

Work load data are fairly well collected in the acute sector. It was necessary for trusts to develop quite robust systems during the purchaser-provider divide because their money depended on their getting clear and accurate evidence of activity. Those systems took a while to develop. The odd thing is that trusts have them in place now they no longer need them, whereas in the early stages of the purchaser-provider system they did not have the data.

The problem with some of the activity data is that, generally, they do not quite fit with reality. For that reason, we suspect that inaccuracies are creeping in. As yet we have very little knowledge about, for example, out-patient data. Some of those data are probably quite significantly flawed. However, we can use postcodes to work out from which areas patients attending the out-patient clinics of hospitals are being referred.

To sum up: the clinical data are flawed, but useful for comparison; the work load data are quite robust; and some of the activity data are erroneous. The difficulty is that unless someone else gathers the same data so that we can make comparisons, it is difficult to offer informed criticism. In some areas we have done that. I chaired part of the acute services review. When looking at neurosurgical activity, we went back to the operating books to see what operations had been done and compared that with the ISD data. Although the data were wrong in places, they were equally wrong for all, so they were still useful.

The Convener: A levelling down.

Ben Wallace (North-East Scotland) (Con): Grampian Health Board is one of the major losers from GMS. Do you agree with its statement, that

"For non cash limited GMS the linkage to consultation rates has also been queried, as this process fails to recognise the complex national payment system in place where circa 60% of spend on GP services is driven by patient head count and not consultation rates."?

Dr Harden: That is a valid point and illustrates the difficulty of the existing collection system, which everyone accepts is not tremendously reliable. All it does is count the number of consultations. It does not count telephone consultations, which are an increasing proportion of consultations in affluent areas, or nurse consultations, or the duration of any consultation.

Mr Hide is right about the accuracy of hospital data. Millions are spent on it. The collection of data from general practices is much poorer. Figures are based on only 6 per cent of practices, which volunteer to collect data and are not usually aware of the purposes for which they will be used. There must, therefore, be considerable doubts about the validity of the data, and the point that Grampian makes is fair.

Dr Garner: Grampian may have made that point because it has been an innovator in primary care and may be ahead of other areas in moving to nurse consultations. You could argue that it has lost out because we are not counting nurse consultations. I do not know the answer, but that is a possible explanation for why it appears to be a bigger loser.

The Convener: That point was raised in other submissions. Lothian Health said that the report does not reward innovation.

Mr Duncan Hamilton (Highlands and Islands) (SNP): Hugh Henry made a point about payment. If the 6 per cent you mentioned is inadequate, what would you deem adequate? Have you estimated the cost if that proportion is changed? Presumably it would have serious implications for any future review.

Dr Harden: That is a complex question. In broad terms, at least 10 per cent of practices should be included for validity and it should be a representative sample rather than a self-selected

group—which may well be practices with more time on their hands and more interest in data collection.

We would have to work out the cost implications.

The Convener: Would you be able to do that?

Dr Harden: Certainly, with the help of our experts, we can estimate the costs.

The Convener: Would it be acceptable in written form?

Hugh Henry: Could you confirm that the practices that participate are those with more time?

Mr Hamilton: I did not understand that either.

Dr Harden: It would seem more likely.

Hugh Henry: You did not say it was more likely, you said it was those with time on their hands.

Dr Harden: It is hard to explain otherwise the fact that a significantly lower percentage of practices in highly deprived areas collect data. As a practising GP, if I were hard-pressed I would be more likely to give time to patient care than to number collecting.

Dr Garner: I think all GPs would argue that they are hard-pressed. We are talking about general practices that have the resources to restructure the working environment to allow them to co-operate in data collection. I would not want the committee to be given the impression that there are GPs sitting around waiting to collect figures.

The Convener: I do not think that we would have inferred that from your comments.

Dr Simpson: I will not mention CMR in relation to hospital activity again, as I have one of the participating practices. [*Laughter.*]

Members: He has time on his hands

The Convener: In that case, can we review our position?

Dr Simpson: My golf handicap does not bear that suggestion out—it has gone up by six.

The answer that Dr Garner gave is correct. We should be able to restructure and to pass on some of the work to nurses and clerical staff. That is a very complex issue relating to inner-city practices and there is much material available on that, which the BMA will know about.

I want to ask a general question about the hospital data. I accept Mr Hide's point about the out-patient data being inadequate. Does he agree that, regarding much of the activity data that were collected, there was almost a perverse incentive to generate activity? Patients were being kept in the secondary care sector inappropriately—and that is still going on. Does Mr Hide have any concerns about the way in which the Arbuthnott report approaches this issue? I ask that in relation to the perverse incentives that it offers by being based on historical data. Innovation is not rewarded, but activity is—even if that activity has been inappropriate.

Mr Hide: One always has some reservations about looking backwards and building a base on what has gone before without considering what will happen in the future.

It is always possible that doctors will be said to be gaming with the system. Figures can be manipulated honestly and patients can be kept in for longer, but that was not done by clinicians. It was done by managers because—for obvious reasons—they had a major vested interest in ensuring that they maximised activity. That has not been the case since the end of the division between purchaser and provider and since the move towards more co-operative developments in health care.

It is in the interests of managers and doctors to be honest and accurate. That is the way ahead that will generate the changes that most of us wish to see in the health service. Your second point was about what, Dr Simpson?

Dr Simpson: Does the report reinforce perverse incentives?

Mr Hide: In the sense that it reinforces the conservative elements in all the health care professions, I would tend to agree that it does.

One must look at the future as well because patient expectations are extremely difficult to define. All the doctors round this table are well aware of the effects of the internet, of increased media interest in health care and of health care technologies. All doctors are subject to increased demands from patients to provide standards of care which, historically, there was neither the funding nor the organisation to provide.

Dr Garner: I would like to say something in relation to Dr Simpson's point, which also relates to the transfer of resources from secondary care to primary care. Primary care has developed considerably, but Dr Simpson's point is that if we were to stick with historical models, resources would stay in the acute sector and would not be transferred to the community and other innovative health care.

We need a formula that will not remain the same for 20 years, but will follow trends in innovation that might occur in the delivery of health care.

The Convener: It was said earlier that this report is about how we carve up the health service cake, and that that is only a part of the wider picture for health care. Kay has a question that

leads on from that.

Kay Ullrich: I have a particular interest in community care and resource transfer from health boards to local authorities. I notice that your contribution mentions the difficulties that are caused by variations in funding from one local authority to another. There appears to be evidence that not every local authority in Scotland is spending the indicative amount for community care. How could the variations in funding between local authorities affect levels of demand on the health service?

10:30

Dr Harden: That is a good point. Arbuthnott does not take existing provision into account in assessing social services resources, but it is a major indication for hospital and general practice services. For example, an inadequate number of nursing home beds creates a backlog of patients who are waiting to be discharged from hospital because there are no nursing home places to move them to. They are the so-called blocked beds; their number varies according to the availability of nursing home beds.

In the community, the provision of support services such as home helps has major implications for patients' ability to receive care in their own homes instead of in a hospital bed. There are many areas in which social service facility provision is an important determinant of health needs and health provision requirements.

Kay Ullrich: It is not usually a shortage of nursing home beds that is the problem; it is usually a shortage of funding.

Dr Harden: You are quite right. The problem is one of the availability of real, funded nursing home beds.

Hugh Henry: We had a submission from a representative of the health councils, who posed a question about health board boundaries and structures and suggested that, for some acute services, it may be more appropriate to consider provision in bigger areas. The converse of that view was the suggestion that, for other services, it might be more appropriate to consider different ways of delivering and holding funds accountable. Kay mentioned bedblocking, but that is not so much an issue of money being available as about money being inappropriately spent on people in the wrong type of facility. Does the BMA think that the provision of community care services would be better managed through one source to get better use and more accountability?

Dr Garner: I will start with the first point about health board boundaries. After the acute services review, we are already examining the provision of services across health board boundaries and the development of the managed clinical networks. That is in its infancy but it is an exciting scheme that will enable us to deliver a better quality of care without there being any postcode-type health board boundaries. That is starting to happen now and we support it.

In answer to the second point, about community care, local health care co-operatives have just been established. We want to encourage dialogue between social services in the LHCC areas and the medical and health facilities in those areas to see whether some form of joint funding can provide better care where the focus is on a smaller community. It is early days yet, but there is certainly potential in that scheme. The BMA does not have a view on whether there should be a single source of funding, but there should certainly be increasing dialogue and co-operation at LHCC level.

The Convener: Unfortunately, colleagues, our time is limited. We shall have a supplementary question from Margaret Jamieson and then a final question from Hugh. After that, we shall have to call it a day. If we have a burning desire to ask any other questions, we can write to you.

Margaret Jamieson: You mentioned the joined-up working of LHCCs and other agencies. I am aware that there have been pilot projects prior to the setting up of LHCCs. There was one in my constituency that involved GP practices and the social work department; the benefit to patients in the area was significant. The pilot project that I am talking about dealt mainly with the elderly, but it is clear that there would be benefits for people of all ages from the type of model that takes a holistic approach to health care.

Dr Garner: We are enthusiastic about looking at examples of good practice. I am not sure which area you are talking about—

Margaret Jamieson: Newmilns.

Dr Garner: Do you know about that project?

Dr Harden: No, but I am certainly familiar with some of the pilot schemes. The BMA strongly supports such pilots and the use of flexible budgeting at LHCC level. Unfortunately, we have not yet seen much sign of a general willingness on the part of social work departments to allocate specific budgets and resources at that level. I know that most LHCCs have invited social work departments to participate, but the uptake has been variable and the willingness to allocate budgets has been minimal.

The Convener: I remember, Margaret, that we discussed the progress of LHCCs some weeks ago. The "Designed to Care" structure is something that the committee will want to come

back to and monitor, and we will want to consider cases of good and bad practice. I call Hugh to ask the final questions.

Hugh Henry: We probably do not have time for both my questions, but I would welcome written comments on my first point. I am concerned by the fact that the remoteness and the islands factor in the Argyll and Clyde Health Board area has not been properly recognised. That has been mentioned already, but I would welcome your further thoughts and suggestions on how that should be tackled.

More generally, some of your comments are based on a presumption that more money is needed. A number of people have made that point, but we are here to look at a report with specific recommendations, notwithstanding your aspirations to have more money for health care in Scotland.

You said that you welcomed the thrust of Arbuthnott. Given the fact that there might be no extra funds, do you think that the report, as brought forward, is the right report with the right recommendations, hitting the right targets and making the right contribution to the allocation of health resources in Scotland? Are there any significant changes that you think should be made to the report that have not been touched on?

Dr Garner: The straight answer is yes. We welcome the Arbuthnott report, but it is a consultation exercise and we think that there should be some tweaking here and there. I hope that, before it is implemented, not as the green book, but with those points taken on board, we can improve on what Arbuthnott has produced.

Our major reservation centres on the indicative GMS. As Mr Chisholm said earlier, it is indicative and we will not necessarily implement it at this stage. Generally, the BMA welcomes the report, recognises that it takes forward the debate on allocation, and supports it. Consultation is on-going and we believe that that process should continue.

Dr Harden: The issue of remoteness is complex, and I will be happy to answer Hugh Henry's question in writing. We are not convinced that remoteness has been properly addressed, particularly for GMS. The major differences in allocation between the comparable areas of the Borders and Dumfries and Galloway are quite clear. The Argyll and Clyde area is another example of incongruity, perhaps because of the fact that there is a huge, high-density population in Paisley, while the rest of the area is sparsely populated, which might produce spurious and inappropriate results.

Mr Hide: The hospital sector is concerned that, without extra funding to oil the changes, there might be a distortion in funding between primary care and the acute sector, which could lead to difficulties in maintaining the service.

Mary Scanlon: What is meant by distortion?

The Convener: I shall ask the witnesses to expand on that in a further written submission. I am aware that our time and yours is constrained. Thank you for coming along and sharing your thoughts with us. As this is the first time that you have addressed the committee, I take this opportunity to record our thanks to your members for the incredible work that they do to promote all that is best in Scottish health. I am sure that we shall meet again. Thank you for your time.

I shall suspend the meeting for a few minutes until the minister arrives.

10:39

Meeting suspended.

10:48

On resuming—

Subordinate Legislation

The Convener: I welcome Iain Gray to the committee once again. An affirmative SSI, the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (North Coast) (Scotland) Order 1999 (SSI 1999/125), is before the committee. As we have already debated similar instruments, I do not expect us to debate this one again. I call the minister to move the motion.

The Deputy Minister for Community Care (Iain Gray): I move,

That the Health and Community Care Committee in consideration of the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (North Coast) (Scotland) Order 1999 (SSI 1999/125) recommends that the Order be approved.

Motion agreed to.

The Convener: Committee members have raised the point that, under rule 10.6.2 of the standing orders, a member of the Scottish Executive or a junior minister must attend to move a motion proposing

"to the lead committee that the committee recommend that the instrument or draft instrument be approved".

I think that our ministers already have far too much on their plate to attend committees and move such motions. Although it is a useful practice to have a junior minister or an official before us to answer questions on important matters or to clarify technical points, it is an unacceptable use of our ministers' time for them to be obliged to attend our

committee in order to place yet another affirmative SSI before us on an issue that we have tackled about 25 times. I mean no disrespect to Iain. Do committee members agree that we should raise the matter with the Procedures Committee?

Members *indicated agreement.*

The Convener: The committee of conveners is also making representations on the timetabling of SSIs, on explanatory notes for SSIs and on committees' need from time to time for officials to answer technical questions about the instruments. However, such sessions should be at the committees' discretion, instead of happening every time.

Thank you, Iain. I think that our business is concluded. Do you want to stay?

Hugh Henry: The minister can stay if he wants.

Iain Gray: No, thank you. My plate is extremely full, though not of scallops.

The Convener: Although we do not want to damage the shellfish industry in Scotland any further, I do not think that committee members will want to see any shellfish for a considerable time.

I suggest that we move to item 5, on future business. Item 4 concerns Dr Forbes's summation on the committee's further work on its draft report on Arbuthnott. However, we should try to keep draft reports under wraps in case our thunder is stolen. Are members agreed? It is agreed.

Future Business

The Convener: Jennifer Smart, the committee clerk, will talk us through item 5.

Jennifer Smart (Committee Clerk): I apologise for the late arrival of the paper. The committee's future business has been fluid in the past couple of days because of the timetabling of the Adults with Incapacity (Scotland) Bill. A motion has been lodged that makes the Justice and Home Affairs Committee the lead committee and the Health and Community Care the secondary committee on the legislation. The Justice and Home Affairs Committee is hearing oral evidence today and will meet again on 9 November. Given the committee's short time scale for stage 1 consideration of the bill, I suggest that this committee appoint a reporter to attend Justice and Home Affairs Committee meetings and to prepare a report on the bill's general principles as they relate to this committee's health remit.

Furthermore, we have to consider the timetable for the Arbuthnott report. Our work on Arbuthnott today should lead to the preparation of a draft report that will be discussed with the convener at some point up to 15 November.

On 16 November, there will be an additional meeting to consider both the report on the Adults with Incapacity (Scotland) Bill, which we will pass to the Justice and Home Affairs Committee, and the draft report on Arbuthnott. Discussion of the latter, it has been suggested, should be in private. I imagine that the committee would wish to keep that in private at that stage.

On 17 November, the minister and deputy minister, Susan Deacon and Iain Gray, will attend the committee, to answer questions that members submitted some time ago, and other questions on general topics. There is also a negative instrument to be considered, and reports will be back from the three groups reporting on smoking, access and poverty.

Given that timetable, consideration of the Stracathro petition will be on 24 November, as will the consideration of the final report on Arbuthnott. The Arbuthnott deadline has now been moved to 3 December, which is why we can spread the consideration of the report to 24 November.

On 1 December, the committee has to decide whether it wishes to consider world AIDS day, and has to approve its final report on Arbuthnott, which is to be submitted to the Executive on 3 December. Some of the evidence that has been submitted to the community care inquiry will be considered by 15 December, when a forward work plan for that inquiry may be decided.

The Convener: Our timetable, and the allocation of lead committees, were given to us only yesterday afternoon, so we have had to make the changes that we are putting to you today at short notice. I am aware that parts of the Adults with Incapacity (Scotland) Bill will be quite contentious and therefore of interest to members. It is important for us to have an input at this early stage, looking at the general principles of the bill. The reporter system is probably the best way of doing that. Members should be considering whether they would like to put themselves forward as reporters.

Because of the time required for our consideration of the Adults with Incapacity (Scotland) Bill, we have had an extension of the time available to consider Arbuthnott. However, that throws up situations such as that on 24 November, when we must consider Stracathro and the final report on Arbuthnott during the same meeting. That will be tight, because I expect that there will be four witnesses on Stracathro, and I had intended to allow a whole meeting for that. I would be interested to hear members' opinions on that.

The request to consider world AIDS day was made to me personally some months back, probably within a week of the committee getting

started. At the time, I said that world AIDS day might be the time to look at HIV and the progress that is being made on that. I am now aware that our time scales are tight, but the committee should make the decision on that.

Malcolm Chisholm: I am not sure exactly what is happening on 16 November, but I am concerned about this committee being scheduled at the same time as others. If there has to be a meeting that week, can it be scheduled so that it does not clash with another committee? I have the Equal Opportunities Committee on that Tuesday, and I am sure that lots of other people have committees on that day as well.

The Convener: We are trying to accommodate that. This committee will be in the morning and the others will be in the afternoon.

Malcolm Chisholm: I do not want to comment on world AIDS day at the moment but, in general, I am aware of people writing to the committee to ask to give evidence. Can those letters be listed, so that we know who is asking to speak to us? The committee could then make decisions on them.

The Convener: There are different approaches. Some people make an approach to me as convener and want to talk only to me. Others are more formal and wish to come before the committee.

I e-mailed members to tell them that—if they agreed—whenever I had meetings with people as the convener, I would circulate information to other members if there was evidence that they might want to hear. I am aware that our work schedule will not allow all the people who want to speak to the committee to give evidence. I understand that.

Hugh Henry: Is it agreed that requests to meet the committee will be put in writing and circulated prior to decisions being made?

The Convener: Yes, with the proviso that, if a request is made to meet me, as the convener, I will circulate the details of that request via e-mail. If other members want to attend such meetings, they will be able to do so. However, organisations are making two distinct approaches: some want to speak only to me; others want to approach the entire committee formally.

11:00

Mr Hamilton: I do not want to appear to take a harsh view on that issue. However, although we should address the matter, what will we achieve by that? Is it simply an awareness-raising exercise, or will the committee assume responsibility for action?

The Convener: Initially, it was intended to raise awareness, and I said that the committee would want to consider the issue. That was four months ago. My crystal ball does not always forecast as far ahead as it might. Although I thought that the committee might want to consider the issue, our present work load means that we should not do that.

As convener, I am undertaking other work that week, to highlight HIV and AIDS as a continuing issue in Scotland. I will be doing other things in which other committee members will be invited to take part, outwith that week's formal committee meeting. That would be the best way for us to proceed.

Hugh Henry: Therefore, is it not on the agenda?

The Convener: The matter was there for discussion.

Dr Simpson: If someone is trying to discuss a topic rationally while it is still being raised as an issue, the chances are not good of arriving at a balanced view. We should take the issue off the agenda and return to it later, as there are problems that concern HIV treatment funding and the effect that it is having on the funding of treatment for drug addiction. There is an issue that must be addressed, but it is inappropriate to raise it while it is in focus.

The Convener: Does the committee share that view?

Dorothy-Grace Elder: You were absolutely right to act on your best intentions, initially, but the problem has caught up with us several months later. You might say that you intended the committee to address the issue, but our schedule has caught up with us. We should dedicate some time to it in the future. As you say, it is an on-going process: we do not want to appear good just for one day. Organisations might give you written submissions, which we could study later, on the adequacies or inadequacies in service provision. We could mark the day in that way, at least.

The Convener: I am sure that that would be satisfactory. Does the committee agree? I want to proceed to the business of the Adults with Incapacity (Scotland) Bill and the Arbuthnott report.

Ben Wallace: Will our meeting on 9 November be rescheduled for 2 pm?

The Convener: Yes.

Ben Wallace: That will cause difficulties. I will attend a meeting of the European Committee in the afternoon.

The Convener: I cannot tell members immediately the constraints of the building, the rooms, and so on. However, it appears that we will have an accommodation problem if the meeting is

held at another time on that day. If you leave that with me, I will find out whether the meeting can be held earlier in the day.

I will check whether we can meet in the morning rather than the afternoon, but it appears that there will be a problem with the on-campus accommodation. We might have to go off campus. There are two or three options of which the clerks have been made aware. If the Health and Community Care Committee met in the morning, our reporter would have to be present at the Justice and Home Affairs Committee, to hear evidence that was being given to that committee.

Hugh Henry: The Justice and Home Affairs Committee is meeting on 9 November at 9.30 am.

We need to be a bit more careful, generally, about the meetings that we schedule and when we schedule them for. I am convener of another committee, with the responsibilities that go along with that. Just as you, convener, have requests to meet people and organisations, I have other things to do. The frequency and length of the meetings that are being scheduled for this committee make it difficult to fit everything in, especially given the starting time of some meetings. It takes some of us two and a half to three hours to get to Edinburgh in the morning. If the committee wants only to respond to the needs of people who live in and around Edinburgh, that is fine, but tell us that. If not, there is a fundamental question about the timing and frequency of meetings, and the fact that they clash with the other demands that members must address. We may have to get through the next few weeks and fulfil the commitments that have been made, but I am not prepared to go on in this way in the new year. It is unacceptable.

Mary Scanlon: I am not sure that I can do justice to the work of the sub-groups that have been set up on smoking, access and poverty, given our work load. I am keen to participate, but if we spread ourselves too thinly, we are not going to achieve anything. Smoking, access and poverty are huge issues. I want to ask committee members to reconsider our decision. I would rather do the job properly than see it half-done.

Things have also moved on at Stracathro. We must make seeing the people from there a priority, whether we go to Brechin or Montrose to see them or they come here.

I ask that we consider leaving the work of the sub-groups until the new year to allow us to meet all the committee's commitments in a professional and responsible manner.

The Convener: The reason that I wanted to discuss the sub-groups was that I was aware that it was several weeks since they had been set up. I know that members have not taken evidence or made particular progress, but have met one another to discuss the issues. It is crucial that we outline the remit and timetable for the sub-groups' work. The remit of the poverty sub-group can become tighter, if that is what members decide. The timetable can also be a lot longer. The scope is there for members to say that, although they want to consider the issues, it will take longer than a month—perhaps six months—to do so.

Hugh Henry: Could not we discuss the remit of the sub-groups on community care and public health and smoking on 15 December, rather than having a huge, general debate on community care? The sub-groups could then start their work in the new year. If we end the year with a long-drawn-out report, then go into recess, we will lose the momentum. I would rather that we started the new year knowing exactly what we intend to do.

The Convener: In that case, we should move the date for the reports on smoking, access and poverty from 17 November to 15 December.

Hugh Henry: We must discuss the remit and the plans for those reports on that date, not the substantive issues.

The Convener: I want to pick up on the general points that Hugh Henry made about work load, timetabling and the starting times of meetings. There are two issues.

I want to put on record the fact that I expressed my deep concern about the timetable for the Adults with Incapacity (Scotland) Bill. We all knew that it was coming up, but I do not think that it is acceptable to have just one day's notice before we start to consider it. I have been informed that, because of the standing orders, we can do nothing but modify our schedule. I find that arrangement unacceptable.

The matter was raised by another convener at the conveners meeting last night and that concern was echoed by other members. The matter is on the timetable for a future meeting of the conveners group. I do not want to be presumptuous, but I think that conveners feel that the way in which committees are being treated is not acceptable. If committees are to focus on reports, we cannot be forced to change our timetables at the last minute.

I am aware that, while we are still in the middle of working on the Arbuthnott report, I for one will now have to turn my attention to the Adults with Incapacity (Scotland) Bill. Both things warrant the full attention of members of the committee. We must not be made to feel that both cannot be adequately covered.

Kay Ullrich: How soon can we expect a briefing on the Adults with Incapacity (Scotland) Bill?

The Convener: Yesterday afternoon, when I found out about this, I asked whether the minister and/or an official could stay on this morning and

give us a briefing. Their timetable may not allow that, but somebody from the legal section should make us aware of exactly what our role would be.

This is the first time that our committee has considered any legislation. If we are to do that, members of the committee are owed a certain amount of respect. We need to know what our role is and what we are expected to do.

Before I come to Malcolm's question, I shall ask Jennifer to clarify the point about the financial resolution.

Jennifer Smart: The bill was introduced on 8 October. It has a financial resolution that, under rule 9.12.6 of the standing orders, has to be passed within three months. Because of the October recess and the December and January recess, the time available to the committee to consider the bill is truncated. The timetable has been approved by the Parliamentary Bureau and by the convener of the lead committee, the Justice and Home Affairs Committee. As a secondary committee, we have to report to that committee.

We are considering only the general principles at this stage. That does not restrict members from lodging amendments or considering the bill during debates in Parliament at stages 2 and 3. Any member can lodge amendments to the bill at those stages. The committee will be taking a narrow look at the bill at this stage.

Kay Ullrich: Will we have a briefing in good time? I would not like to get the briefing on 16 November. This is the first time that we have dealt with legislation, and I would like to think that we will be better briefed than we have been in the past.

The Convener: A written briefing has been prepared by SPICe. I have also been given some background information and explanatory notes to the bill. Do members have access to that information?

Jennifer Smart: Those documents are available in the document supply centre.

The Convener: I suggest that the clerks order up copies for all members to ensure that everyone has them.

Ben Wallace: After the bill comes before this committee for consideration of general principles, does it goes back into the chamber?

The Convener: It goes to the Justice and Home Affairs Committee. It must reach it by 22 November.

Dr Simpson: We can attend the Justice and Home Affairs Committee to propose amendments at stage 2.

Hugh Henry: You suggested two possibilities, Margaret: one was to invite the minister to explain the bill and the other was to invite legal officers. I do not think that it would be helpful to invite any ministers.

The Convener: We had a minister with us this morning and I asked whether—

Hugh Henry: That would not have been helpful; it would have confused us. We do not want to duplicate the work of the Justice and Home Affairs Committee, so it would be helpful if someone can clarify our role and explain what is required of us, legally and procedurally. Perhaps we could have a brief on the issues we should look at as a committee so that we do not wander all over the place and waste time.

11:15

The Convener: That is what I meant by saying that, given the short notice, we should attempt to get a handle on what we are expected to do in relation to the bill, rather than being left with more questions and with, yet again, no one to ask.

Malcolm Chisholm: I do not think it is acceptable for this committee to meet at the same time as the European Committee. You may have answered this question already, but why are we not having a meeting on 10 November? Why is there no room when we are scheduled to meet every Wednesday morning? If there is no committee room available, it would still be better for us to meet somewhere that morning, rather than have a meeting on the 9th that half of the committee cannot attend.

Kay Ullrich: We would have to rejig everything.

Malcolm Chisholm: I cannot attend on 9 November—a lot of us cannot.

The Convener: We will try to move the meeting. Our initial intention was to meet fortnightly, not weekly, but the work load has changed. There is a problem with the availability of rooms.

Malcolm Chisholm: Given that we would be meeting to consider the interim reporter's findings, it would be appropriate to meet in private session so that we do not have to bother about microphones and suchlike. A meeting that people can attend would be preferable to one with microphones and nobody to speak into them.

Hugh Henry: I know that Mary said the Stracathro issue has moved on, but there is an issue of principle. There was a debate on Stracathro and now there is an attempt to bring it back to this committee. We need to decide whether matters that are the responsibility of health boards should come to us, given that we cannot change the views of health boards.

In general, are we as a committee prepared to

accept all local issues that are a source of concern? There could be similar issues in Fife and possibly in my own area. As a local member, I would not want to agree to certain things here and then find that, in my own area, similar things were not being properly attended to. If we are happy for a succession of local issues to come to the committee, we should say so up front so we can all raise issues.

The Convener: The Stracathro business was referred to us by the Public Petitions Committee. We discussed earlier the danger of looking at local rather than strategic and national issues. I certainly took the view that some of the things that people from Stracathro raised with us when we met them after a committee meeting, such as consulting with staff and similar issues, were the kinds of issues on which the committee could have some input.

The Public Petitions Committee has asked us to address the Stracathro problem. That petition has 25,000 signatures on it. You might call me populist, but I think that we must do something with a petition of that size. The Public Petitions Committee is also aware of how things are moving through the committee structure.

Hugh Henry: I am not objecting to that. All I am saying is that I want a principle established that if other issues from other committees come to us in that way, we will have a procedure for dealing with them. We must be clear that we are setting precedents. Once that is done, others have the right to expect us to continue in that way, and the expectation that we will deal with everyone equitably.

Mr Hamilton: Can I clarify that the principle would be that the petition would come to the committee so that the committee could decide whether to look at it or not? That does not mean that we will look at every petition.

Hugh Henry: Why not?

Mr Hamilton: We must exercise judgment as to whether or not we want to look at a petition.

The Convener: Because loads of petitions come in.

Hugh Henry: Exactly, Margaret.

Dr Simpson: Would we not review each petition on a case-by-case basis?

The Convener: As someone who sits on the Public Petitions Committee—although I must apologise for missing it yesterday—I would like to point out that there are a number of petitions undergoing consideration. Some committees are getting more of their work load in that way than others. So far, the impact of petitions on our work load has been quite slight. At one of the Public Petitions Committee meetings, five items were sent to the Transport and the Environment Committee. That committee could not set a precedent that because one of those five is something that it ought to consider, all five must be considered. Every Public Petitions Committee meeting that I have been at has resulted in the bulk of petitions being sent on to the Transport and the Environment Committee.

The only way in which we can deal with petitions is to look at each one on a case-by-case basis as it comes to us. We must also bear in mind that the Public Petitions Committee is a vehicle of which many people are not yet aware. When it becomes a better-publicised, well-oiled machine, even more people will make use of it. The Public Petitions Committee is simply passing things along; it is not making judgments about the contents of the petitions. It is up to us as a committee to do that.

Dr Simpson: That is the point. What exactly does the Public Petitions Committee do, if it does not say that the locus of this Parliament in relation to those petitions is to look at X? Hugh is right. If the Public Petitions Committee is simply forwarding petitions to us and saying that they are administratively correct—they meet the terms required of a petition—then the committees will be totally swamped by that process.

This committee has decided that it must examine the process by which things were moved around in Stracathro. That is reasonable, but the Public Petitions Committee must act on the Parliament's behalf and it should have said that it thought that the petition was valid and that the Health and Community Care Committee might wish to look at the concerns of this group in relation to the process of what happened in Stracathro. We will not talk about the acute services review in relation to Tayside. If we do, we are lost.

The Convener: The Public Petitions Committee works in the way that you described. Petitions come forward and, if they are administratively correct, they are passed on.

Dr Simpson: We do not need a committee to decide that. That would be one committee less.

The Convener: The other aspect of the Public Petitions Committee's work is that it monitors what has happened to those petitions it has referred on. You may laugh, Hugh—

Dr Simpson: Our clerical staff would be good at that. They could provide a turnaround timetable and state when the petition had to be returned.

The Convener: I am not the convener of the Public Petitions Committee. You might like to take that up with him. There was a strong feeling that the way in which petitions were dealt with in

Westminster could be improved. That process was not open and transparent and, because of that, there has been a view that this is a better way forward.

If you look at previous meetings of the Public Petitions Committee, Hugh, you will see that the points that you and Richard have raised were raised several times by me in the initial meetings of the Public Petitions Committee. I know that you have better things to do with your time than to search out my words but, as a committee convener, I have the same concerns that you do. I can see what is going to happen in future when this route is better travelled by more people.

Hugh Henry: Can we refer our concerns to the Public Petitions Committee? Will you, convener, also tell the conveners group that this committee is concerned that the Public Petitions Committee should not be merely an administrative vehicle for passing petitions on to other committees, and then monitoring whether those other committees have examined the petitions?

The Public Petitions Committee should attempt to establish the role of Parliament and of specific committees in relation to specific issues, so that committees are charged with examination of those issues. Committees can then be held to account as to whether that has been achieved.

If the Public Petitions Committee is simply a pass-through mechanism, then 129 MSPs will use it to play a local publicity game and the system will grind to a halt. We must give added value to the process and, so far, I cannot see what added value we have been asked to contribute.

We should also, perhaps, refer our concerns to the Procedures Committee. That committee is examining a number of issues and this should be one of them.

The Convener: Is that agreed to?

Members *indicated agreement.*

Mary Scanlon: I agree that that is a fair point, but the structure should not be so rigid that people feel that they do not have access to it. Flexibility and discretion should be used occasionally and the Public Petitions Committee should not be seen as an obstacle.

Hugh Henry: The only danger is that flexibility and discretion are issues that are important to Mary Scanlon, but they might not mean the same to me. There will be 129 versions of flexibility and discretion.

The Convener: We will make decisions issue by issue in regard to the petitions that are brought before us. We are concerned about the way in which the Public Petitions Committee must function and that is reasonable because our work plan might be swamped because of that.

This Parliament is trying to do things in a different way to Westminster and, although I can appreciate the thinking behind the actions of the Public Petitions Committee, we must say that it would be helpful if the Public Petitions Committee were more specific regarding the remit that they are passing forward. That committee should not simply take a petition lock, stock and barrel and pass it on.

You and I might be more likely to think of a petition as something which someone has gone round the doors with and collected 25,000 signatures on, but a petition can come from any member of the public in Scotland. There are petitions from individuals and petitions from 25,000 people. That provides wide scope to affect the work of the Parliament.

Ben Wallace: I would like to come back to the point. If we do that to the Public Petitions Committee, we must send them guidelines on what we feel we are competent to deal with. As a result, when a health petition comes before them, they will know what we will and will not consider.

Kay Ullrich: Such guidelines will evolve.

The Convener: No. I do not want to get into the specifics of the technicalities of the Public Petitions Committee, but we cannot do that at the moment, Ben. We will tell the Public Petitions Committee and, I hope, the Procedures Committee and the conveners group in what direction we think we are going to have to work. My understanding is that the Public Petitions Committee is there to pass petitions on. As far as I am aware, the only thing that that committee has said no to is a petition that was procedurally wrong.

Ben Wallace: What is the point of that?

The Convener: I tried to outline to you the thinking in terms of openness and transparency.

Ben Wallace: If that committee is to be a sifter, then who decides on how the sift is done? Is that decided by the Public Petitions Committee or by the other committees?

The Convener: We should put forward our general concerns about how the system functions. We can then hear back from the Public Petitions Committee and the Procedures Committee. If those committees require more information from us regarding those concerns, we will supply it. I will speak to Murray Tosh about this issue.

I would like to move the committee on to two of the main things that we still have to do in relation to the report. Section 4.2 asks us to consider part 5 of the Adults with Incapacity (Scotland) Bill and to agree the appointment of a reporter on the bill.

The reporter will have to listen in to what the Justice and Home Affairs Committee is doing with the bill and will be able to attend that committee's meetings.

Would anybody be willing to act as a reporter?

11:30

Dr Simpson: I would volunteer, but I am a member of three committees at the moment so I will rule myself out.

Kay Ullrich: I will rule myself out, too.

The Convener: I am aware that there are members who would like to do this but will be unable to do so due to pressure of work.

Mary Scanlon: It is difficult to cope with the work that we have.

Ben Wallace: We need to look at the timetable of the Justice and Home Affairs Committee.

The Convener: In the absence of a volunteer, I should act as reporter. However, as the Parliamentary Bureau has not come to an agreement on the election of deputy conveners, if I even leave this room to go to the toilet, the meeting stops. If our committee has to meet at the same time as the Justice and Home Affairs Committee, I cannot be the reporter.

Mr Hamilton: Would it be possible for the reporter simply to read copies of the *Official Report* of the Justice and Home Affairs Committee? Why does anyone have to attend the committee's meetings?

The Convener: As you know, we have a problem in terms of the time that it takes for the *Official Report* to be published, which means that the reporter might not see a copy for a few days.

Another aspect is that a reporter who attended the meeting would be able to ask questions, as would other members of this committee who chose to attend.

Mr Hamilton: There would be a time lag between the meeting of the Justice and Home Affairs Committee and the report of whoever had attended the committee anyway, so what are we losing?

The Convener: That is true, but that time would allow them to formulate some of the points that were raised that were relevant to health.

Mr Hamilton: I am not trying to be awkward but—

The Convener: The reporter would serve as a sort of early warning system. Also, having a member of this committee attending that committee would allow us to ask questions at an early stage.

As you can imagine, Duncan, only having had since 4 o'clock yesterday afternoon to deal with this has not allowed us to come up with anything more than the suggestions that we have in front of us.

Do we have any volunteers at all?

Ben Wallace: What date is it?

Kay Ullrich: We have a volunteer.

Ben Wallace: One never volunteers for anything in the army but I will volunteer for this because I cannot stand waffle and I want to get something done.

The Convener: It is on a Tuesday morning, Ben.

Ben Wallace: I will do it.

The Convener: We should all say thank you to Ben Wallace for agreeing to act as the reporter.

The clerks will give you a briefing after today's meeting, Ben.

Any members of this committee are welcome to attend the meeting of the Justice and Home Affairs Committee on 9 November.

Are we agreed that we can take the work programme on board, with the proviso that we will sort out the timetabling clashes?

Members *indicated agreement.*

The Convener: I appreciate the patience of the committee members and, as Margaret Jamieson suggested, we will try to ensure that we are in a much better position to concentrate on the matter in hand in the new year.

Malcolm Chisholm: Something has just occurred to me, although I might be making an elementary error. I have not read the minutes of the Finance Committee's last meeting—perhaps Richard Simpson can help me—but I understand that we have new procedures on budgets. I thought that committees had a role in scrutinising the budget at this stage. Will we have more work that we have not taken account of?

Dr Simpson: Not this year. We will have extra work next year, though.

The Convener: So that is next year's learning curve.

I would like to draw the public part of the meeting to a close and move into private session to consider John Forbes's submission and to discuss the report without the presence of the official reporters and without the presence of the broadcasters.

11:35

Meeting continued in private.

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